State West Virginia

4.19 Payments for Medical and Remedial Care and Services

& (b).

E. Manufacturer Restriction: Reimbursement for prescribed drugs will be limited to those drugs supplied from manufacturers that have signed a national agreement in accordance with Section 1927 of the Social Security Act (the Act), (as amended by Section 4401 of P.L. 101-508). New biologicals or drugs approved by the Food & Drug Administration on or after the enactment of Section 4401 of P.L. 101-508 are covered without restriction for a period of six months except drugs excluded from coverage in Section 1927(d)(2) of the Act.

12. b. Dentures

Payment for dentures is included in item 10.

c. Prosthetic Devices

Payment is based on the upper limit established for the service by Medicare.

d. Eyeglasses

Payment will not exceed an upper limit established considering cost information from national sources; i.e., Optometry Today and Review of Optometry; a survey of practitioners in the State; and the upper limits established by Medicare adjusted to reflect complexity of material.

An upper limit is established for each lens code. The upper limit for frame is wholesale cost up to $40.00 multiplied by a factor of 2.5. Payment for low vision aids may not exceed invoice cost plus 30 percent.

Reimbursement may not exceed the provider's customary charge for the service to the general public.

13. d. Rehabilitative Services

Behavioral Health Services

1) Reimbursement to those agencies licensed as behavioral

State West Virginia

4.19 Payments for Medical and Remedial Care and Services

health agencies only is based on payment rates for each service by units of time with limitations established for occurrences. The payment upper limit is established by arraying charges of providers for the services to establish a reasonable customary and prevailing charge.

2) Reimbursement to those providers dually licensed as Behavioral Health and Residential Child Care Facilities will be prospective based on allowable provider specific cost for treatment within each peer group level. Reimbursement will be capped for individual providers within each *peer group* level based on allowable provider specific cost.

Allowable *Provider Specific* Cost
Reimbursement for Behavioral Health Residential Child Care Facilities is limited to those costs required to deliver allowable medically necessary behavioral health treatment services by an efficient and economically operated provider. Costs determined to be reasonable and allowable, *by the Department*, will be reimbursed up to the level of the peer group ceiling derived from the weighted average cost of providers by peer group. The costs specifically exclude costs for room, board, and the minimum supervision required by Social Services licensing regulations.

Peer Group Ceiling
The peer group ceiling will be derived from the weighted average per patient day treatment costs of all providers, at an assumed occupancy of 90%, in the peer group, plus 5%.

State West Virginia

4.19 Payments for Medical and Remedial Care and Services

Efficiency Allowance
When a provider's actual allowable per diem costs are below the peer group ceiling an incentive of 50% of the difference between the provider's allowable cost and the peer group ceiling within each level of care (if lower than the peer group ceiling) will be paid, up to a maximum of $4 per resident day.

Inflation Factor
A factor will be assigned to cost as a projection of inflation for subsequent rate setting cycles. Changes in industry wage rate and supply costs compared with CPI are observed and the lesser amount of change is expressed as a percentage and applied to the allowable reimbursable costs for the six-month reporting period. ***This inflation factor represents the maximum rate of inflation recognized by the Department for the rate period.***

Cost Reporting, Rate Periods
Cost reports must be filed with the State agency. postmarked within 60 days following the end of each six month cost reporting period; January 1 - June 30 and July 1 - December 31. ***Rates will be calculated and effective for six month periods starting three months after their reporting period.***

Example of Calculations:
Peer group of 3 (three) providers A, B, and C with following data -

Provider	Beds	Patient Days (6 months)	Allowable Treatment Costs
A	9	1458	$77,760 ($60 ppd)
B	7	1134	$73,710 ($65 ppd)
C	18	2916	$153,900 ($50 ppd)

ATTACHMENT 4.19-B
Page 11-b

State West Virginia

For this example only, assumed 180 days in six month reporting period, actual days will be utilized during actual calculations, and an increase in the inflation rate of 1%.

Peer Group Ceiling Calculation

Provider	Allowable Costs	@90% Occupancy
A	$77,760	$69,120
B	$73,710	$73,710
C	$153,900	$162,450
Total		**$305,280**

Weighted average per patient day allowed treatment cost ($305,280/5508 days) of $55.42 plus 5% ($55.42 x .05) of $2.77 totals $58.19, for the peer group ceiling.

Individual Rate Calculation

Provider	PPD Cost	Lower of PPD or PGC	Efficiency Incentive	1% Inflation	Provider Specific Rate
A	$60.00	$58.19	$0	$0.58	$58.77
B	$65.00	$58.19	$0	$0.58	$58.77
C	$50.00	$50.00	$4	$0.54	$54.54

17. **Nurse Midwife Services**

Payment may not exceed the amount paid to physicians for the services the provider is authorized by State law to perform or the provider's customary charge, whichever is less.

For services provided on and after 11-1-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level date for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

State West Virginia

4.19 Payments for Medical and Remedial Care and Services

18. a. Hospice Reimbursement - General

Payment for hospice care is made at one of four predetermined Medicare rates for each day in which an individual is under the care of the hospice. These rates are established by Medicare for the hospice, and will apply to payment for Medicaid recipients who are not eligible for Medicare. The Medicare rates are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Medicaid pays the Medicare coinsurance for dually eligible individuals.

b. Nursing Facility Residents

When hospice care is furnished to a Medicaid recipient residing in a nursing facility the hospice is paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. This additional amount paid to the hospice must equal at least 95 percent of the per diem rate that would have been paid by Medicaid for that individual.

The hospice is responsible for "room and board" which includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medications, maintaining cleanliness of the resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

c. Limitation on Payment for Inpatient Care

Limitation on payment for inpatient care will be calculated according to the number of days of inpatient care furnished to Medicaid patients. During the 12 month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period.

State West Virginia

4.19 Payments for Medical and Remedial Care and Services

d. Cap on Overall Hospice Reimbursement

The overall aggregate payments made to a hospice during a cap period from November 1 of each year through October 31 of the next year will be limited based on services rendered during the cap year on behalf of all Medicaid recipients receiving services during the cap year. Any payments in excess of the cap must be refunded by the hospice.

19. Case Management

Reimbursement for case management services provided under the plan will be based on actual cost; i.e., established hourly rates for units of service provided. Payment for case management services will not duplicate payment made to public agencies or private entities under other program authorized for the same purpose. Medicaid will be the payor of last resort.

20. c. Expanded Prenatal Services

Reimbursement for expanded prenatal care services, as defined in Supplement 2 to ATTACHMENT 3.1-A and 3.1-B, 20.c., will be based on units of services. Each defined activity will be weighted and assigned a time value which will convert to dollars for reimbursement purposes.

Payment for expanded prenatal services will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid will be the payor of last resort.

22. Respirator Care Services

Payment is made for ventilator equipment and supplies, the respiratory therapist, or other professional trained in respiratory therapy, at the lowest customary charge from qualified providers serving the geographical area of the recipient's residence.

State: West Virginia

4.19 Payments for Medical and Remedial Care and Services

23. Pediatric or Family Nurse Practitioner Services

Payment may not exceed the amount paid to physicians for the service the provider is authorized by State Law to perform, or the provider's customary charge, whichever is less.

For services provided on and after 11-1-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

1. a. Transportation

Payment is made for transportation and related expenses necessary for recipient access to covered medical services via common carrier or other appropriate means; cost of meals and lodging; and attendant services where medically necessary.

Reimbursement Upper Limits:

(i) Common Carriers (bus, taxi, train or airplane) - the rates established by any applicable regulatory authority, or the provider's customary charge to the general public.

(ii) Automobile - Reimbursement is computed at the prevailing state employee travel rate per mile.

(iii) Ambulance - Reimbursement is the lesser of the Medicare geographic prevailing fee or EMS provider charge to the general public as reported on the State Agency survey.

(iv) Meals - $5.00 per meal during travel time for patient, attendant, and transportation provider.

Lodging - At cost, as documented by receipt, at the most economical resource available as recommended by the medical facility at destination.

School Health Services-Speciality Transportation

Reimbursement for transportation services shall be fee-for-service. Reimbursement interim rates are based on statewide historical costs for specialty transportation services. Per diem reimbursement shall be available when services are appropriately documented, pursuant to Medicaid billing requirements. Costs not to exceed actual, reasonable costs and must be cost settled on an annual basis.

4.19 Payments for Medical and Remedial Care and Services

ATTACHMENT 4.19-B (Continued)

Methods and Standards for Establishing Payment Rates

(iv) Meals - $3.00 per meal during travel time

Lodging - the most economical resources available recommended by the medical facility at destination.

24. f. Personal Care Services in Recipient's Home

Reimbursement for personal care services will be a monthly rate based on units of service authorized in the approved care plan. Each specific activity required by the care plan will be weighted and assigned a unit or point value which will have a dollar value attached. Payment for personal care services under the State Plan will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid will be the payor of last resort.

24. g. Rural Primary Care Hospitals - Outpatient Services

The hospital may elect one of the following methodologies for payment of outpatient services:

a. Cost based payment plus professional services. This payment does not include payment for physician services or other professional medical services paid on a charge or other fee basis, and billed separately to a carrier under Medicare.

b. All inclusive rate method. This payment combines facility services and professional medical services into an all-inclusive rate per visit based on reasonable costs. The principle of the lesser of costs or charges does not apply.

c. The State assures that payment for outpatient hospital and clinic services will not exceed the Medicare upper limit at 42 CFR 447.321.